

**THIS DECISION HAS BEEN APPEALED. THE FOLLOWING  
IS THE RELATED SOAH DECISION NUMBER:**

**SOAH DOCKET NO. 453-05-3152.M5**

MDR Tracking Number: M5-04-3488-01

Under the provisions of Section 413.031 of the Texas Workers' Compensation Act, Title 5, Subtitle A of the Texas Labor Code, effective June, 2001 and Commission Rule 133.305 titled Medical Dispute Resolution- General, 133.307 titled Medical Dispute Resolution of a Medical Fee Dispute, and 133.308 titled Medical Dispute Resolution by Independent Review Organizations, the Medical Review Division assigned an IRO to conduct a review of the disputed medical necessity issues between the requestor and the respondent. This dispute was received on 6-14-04.

The IRO reviewed therapeutic exercises, aquatic therapy, manual therapy, chiropractic manual treatment, massage, office visits, muscle testing, ROM, physical performance test, gait training, mechanical traction, physician review, electrical stimulation (unattended), and whirlpool from 8-5-03 through 1-28-04.

The Medical Review Division has reviewed the IRO decision and determined that the **requestor prevailed** on the issues of medical necessity. Therefore, upon receipt of this Order and in accordance with §133.308(r)(9), the Commission hereby orders the respondent and non-prevailing party to **refund the requestor \$460.00** for the paid IRO fee. For the purposes of determining compliance with the order, the Commission will add 20 days to the date the order was deemed received as outlined on page one of this Order.

In accordance with §413.031(e), it is a defense for the carrier if the carrier timely complies with the IRO decision.

This dispute also contained services that were not addressed by the IRO and will be reviewed by the Medical Review Division. On 7-20-04, the Medical Review Division submitted a Notice to requestor to submit additional documentation necessary to support the charges and to challenge the reasons the respondent had denied reimbursement within 14 days of the requestor's receipt of the Notice.

**DOS 8-12-03: Code 97113 (2 units): .**

**DOS 10-7-03: Codes 95851, 97750, and 99213:**

**DOS 11-25-03: Codes 97110 and 99213:**

Carrier states they did not receive initial bill for these disputed dates of service.

Per Rule 133.307(e)(2)(B), the requestor shall include a copy of each EOB, or if no EOB was received, convincing evidence of carrier receipt of that request. Requestor submitted a signed certified mail receipt as convincing evidence of carrier receipt of request for an EOB. Per Rule 133.307(e)(3)(B), the carrier is required to provide any missing information including absent EOBs not submitted by the requestor. The carrier's initial response to the medical dispute did not include the missing EOBs for these disputed dates of service. Therefore, reimbursement recommended as follows:

- 97113 – MAR is  $\$29.27 \times 2 = \$58.54 \times 125\% = \$73.18$
- 95851 – MAR is  $\$26.72 \times 125\% = \$33.40$
- 97750 – MAR is  $\$28.21 \times 125\% = \$35.26$
- 99213 – MAR is  $\$50.25 \times 125\% = \$62.81 \times 2 \text{ DOS} = \$125.62$
- 97110 - RATIONALE: Recent review of disputes involving CPT code 97110 by the Medical Dispute Resolution section as well as analysis from recent decisions of the State Office of Administrative Hearings indicate overall deficiencies in the adequacy of the documentation of this code both with respect to the medical necessity of one-on-one therapy and documentation reflecting that these individual services were provided as billed. Moreover, the disputes indicate confusion regarding what constitutes “one-on-one”. Therefore, consistent with the general obligation set forth in Section 413.016 of the Labor Code, the Medical Review Division (MRD) has reviewed the matters in light of the Commission requirements for proper documentation. The MRD declines to order payment for code 97110 because the daily notes did not clearly delineate the severity of the injury that would warrant exclusive one-to-one treatment.

**DOS 8-27-03: Codes 97113 (2 units) and 97124.**

Denied by the carrier as “F – physical medicine and rehabilitation services may not be reported in conjunction with an evaluation and management code performed on the same day.” The Trailblazer Local Coverage Determination (LCD) states in part, “When both a modality/procedure and an evaluation service are billed, the evaluation may be reimbursed if the medical necessity for the evaluation is clearly documented. Standard medical practice may be one or two visits in addition to physical therapy treatments. Reimbursement beyond this standard utilization requires documentation supporting the medical necessity for the office visit.”

The LCD does not prohibit the billing of physical medicine and rehabilitation services with evaluation and management codes. Therefore, recommend reimbursement as follows:

- 97113 – MAR is  $\$29.27 \times 2 = \$58.54 \times 125\% = \$73.18$
- 97124 – MAR is  $\$21.71 \times 125\% = \$27.14$

**DOS 9-25-03: Code 97140.**

**DOS 10-13-03: Code 97113 (3 units).**

**DOS 1-19-04: Codes 97110 (2 units), 97113 (2 units), and 99213.**

The carrier denied these services/treatments on these dates of service; however, neither party submitted EOBs. Per Rule 133.307(e)(2)(B), the requestor shall include a copy of each EOB, or if no EOB was received, convincing evidence of carrier receipt of that request. Requestor submitted a signed certified mail receipt as convincing evidence of carrier receipt of request. Per Rule 133.307(e)(3)(B), the carrier is required to provide any missing information including absent EOBs not submitted by the requestor. The carrier’s initial response to the medical dispute did not include the missing EOBs for these disputed dates of service. Therefore, reimbursement recommended as follows:

- 97140 – the MAR is  $\$26.04 \times 125\% = \$32.55$
- 97113 – MAR is  $\$29.27 \times 3 = \$87.81 \times 125\% = \$109.76$  for DOS 10-13-03.
- 97113 – MAR is  $\$32.57 \times 2 = \$65.14 \times 125\% = \$81.43$  for DOS 1-19-04.
- 99213 – MAR is  $\$32.57 \times 125\% = \$40.71$
- 97110 - RATIONALE: Recent review of disputes involving CPT code 97110 by the Medical Dispute Resolution section as well as analysis from recent decisions of the State Office of Administrative Hearings indicate overall deficiencies in the adequacy of the documentation of this code both with respect to the medical necessity of one-on-one therapy and documentation reflecting that these individual services were provided as billed. Moreover, the disputes indicate confusion regarding what constitutes “one-on-one”. Therefore, consistent with the general obligation set forth in Section 413.016 of the Labor Code, the Medical Review Division (MRD) has reviewed the matters in light of the Commission requirements for proper documentation. The MRD declines to order payment for code 97110 because the daily notes did not clearly delineate the severity of the injury that would warrant exclusive one-to-one treatment.

Code 99080-73 was billed for date of service 12-19-03 and denied as “V – unnecessary medical”; however, per Rule 129.5, the TWCC-73 is a required report and is not subject to an IRO review. The Medical Review Division has jurisdiction in this matter; therefore, recommend reimbursement of \$15.00.

The above Findings and Decision is hereby issued this 10th day of November 2004.

Dee Z. Torres  
Medical Dispute Resolution Officer  
Medical Review Division

### **ORDER**

**On this basis, and pursuant to §§402.042, 413.016, 413.031, and 413.019 of the Act, the Medical Review Division hereby ORDERS the Respondent to pay the unpaid medical fees outlined above as follows:**

- In accordance with the fair and reasonable rate as set forth in Commission Rule 133.1(a)(8) for dates of service through July 31, 2003;
- In accordance with Medicare program reimbursement methodologies for dates of service on or after August 1, 2003 per Commission Rule 134.202 (c);
- plus all accrued interest due at the time of payment to the requestor within 20 days of receipt of this Order.

This Order is applicable to dates of service 8-5-03 through 1-28-04 as outlined above in this dispute.

The respondent is prohibited from asserting additional denial reasons relative to this Decision upon issuing payment to the requestor in accordance with this Order (Rule 133.307(j)(2)).

This Order is hereby issued this 10th day of November 2004.

Roy Lewis, Supervisor  
Medical Dispute Resolution  
Medical Review Division

September 1, 2004

### **NOTICE OF INDEPENDENT REVIEW DECISION**

**RE: MDR Tracking #: M5-04-3488-01**  
**TWCC #:**  
**Injured Employee:**  
**Requestor:**  
**Respondent:**  
**----- Case #:**

----- has been certified by the Texas Department of Insurance (TDI) as an independent review organization (IRO). The ----- IRO Certificate Number is 5348. Texas Worker's Compensation Commission (TWCC) Rule §133.308 allows for a claimant or provider to request an independent review of a Carrier's adverse medical necessity determination. TWCC assigned the above-reference case to ----- for independent review in accordance with this Rule.

----- has performed an independent review of the proposed care to determine whether or not the adverse determination was appropriate. Relevant medical records, documentation provided by the parties referenced above and other documentation and written information submitted regarding this appeal was reviewed during the performance of this independent review.

This case was reviewed by a practicing chiropractor on the ----- external review panel who is familiar with the condition and treatment options at issue in this appeal. The reviewer has met the requirements for the ADL of TWCC or has been approved as an exception to the ADL requirement. The ----- chiropractor reviewer signed a statement certifying that no known conflicts of interest exist between this chiropractor and any of the treating physicians or providers or any of the physicians or providers who reviewed this case for a determination prior to the referral to ----- for independent review. In addition, the ----- chiropractor reviewer certified that the review was performed without bias for or against any party in this case.

#### Clinical History

This case concerns a male who sustained a work related injury on ----- . The patient reported that while at work he fell from a scaffold injuring his left shoulder and back. The patient was evaluated in an emergency room where he was diagnosed with a left shoulder dislocation and a L3 compression fracture. The patient underwent a closed reduction of the left dislocated shoulder and a CT scan. A MRI of the left shoulder and lumbar spine performed on 6/16/03 indicated a Hill Sachs impaction fracture involving the lateral humeral head, a 4-5mm full

thickness tear involving the lateral insertion supraspinatus tendon, compression fracture of L3 with L2/3 right paracentral 3-4mm discal substance herniation contacting and minimally indenting the expected thecal sac contours, a 2-3mm posterocentral discal substance herniation at L4/5, and a 2-3mm posterocentral discal substance herniation at L5/S1. Initially the patient was treated conservatively and subsequently underwent left shoulder surgery consisting of a mini-arthrotomy and open repair of the full thickness tear of the rotator cuff on 10/30/03. The patient was treated postoperatively with physical therapy progressing to a work hardening program.

#### Requested Services

Therapeutic exercises, aquatic therapy, manual therapy, chiropractic manual treatment, massage, office visits, muscle test, ROM, physical performance test, gait training, mechanical traction, physician review, electrical stimulation, unattended, and whirlpool from 8/5/03 through 1/28/04.

#### Documents and/or information used by the reviewer to reach a decision:

##### *Documents Submitted by Requestor:*

1. Position Statement 7/27/04
2. SOAP Notes 8/5/03 – 1/28/04
3. MRI report 6/16/03
4. Ortho Notes 8/25/03 – 1/26/04

##### *Documents Submitted by Respondent:*

1. No documents submitted

#### Decision

The Carrier's determination that these services were not medically necessary for the treatment of this patient's condition is overturned.

#### Rationale/Basis for Decision

The ----- chiropractor reviewer noted that this case concerns a male who sustained a work related injury to his left shoulder and back on -----. The ----- chiropractor reviewer indicated that this patient sustained a complex injury that was initially treated with conservative care. However, the ----- chiropractor reviewer explained that this treatment did not resolve this patient's pain and that the patient subsequently underwent a surgical repair of the left shoulder. The ----- chiropractor reviewer noted that the patient was braced for an extended amount of time for an L3 compression fracture simultaneously. The ----- chiropractor reviewer indicated that the patient then required strengthening therapy once the brace was removed in early 10/03. The ----- chiropractor reviewer also indicated that the patient required postoperative therapy to help control pain and restore function. The ----- chiropractor reviewer explained that this therapy would be required for approximately 8-10 weeks. The ----- chiropractor reviewer indicated that therapy for the low back pain at the same time is reasonable due to the nature of the injuries.

The ----- chiropractor reviewer explained that the treatment rendered to this patient does follow the outline for surgical repair of a shoulder. The ----- chiropractor reviewer also explained that the patient never reached maximum medical improvement during the treatment in question. Therefore, the ----- chiropractor consultant concluded that the therapeutic exercises, aquatic therapy, manual therapy, chiropractic manual treatment, massage, office visits, muscle test, ROM, physical performance test, gait training, mechanical traction, physician review, electrical stimulation, unattended, and whirlpool from 8/5/03 through 1/28/04 were medically necessary to treat this patient's condition.

Sincerely,